COMPREHENSIVE RISK COUNSELING AND SERVICES FOR PERSONS LIVING WITH HIV

DESCRIPTION

Comprehensive Risk Counseling and Services (CRCS), formerly Prevention Case Management (PCM), is a client-centered HIV prevention activity. Originally, CRCS was conceived as a combination of HIV risk-reduction counseling and conventional case management for persons at high risk of transmitting or acquiring HIV. As such, CRCS typically provided intensive, ongoing, individualized prevention counseling, support, and service brokerage. However, information from CRCS demonstration projects indicates that a more successful model for CRCS for HIV-infected persons clearly defines the prevention case manager's primary role as a prevention counselor, working closely with existing case management systems to provide other services to clients. Where such case management systems are not available, the prevention case manager is still encouraged to support the client by providing traditional case management services such as linkage to needed services.

Priority for CRCS services should be given to HIV-infected persons who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection.

Goal

The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs.[1,2]

How It Works

CRCS provides multiple sessions of client-centered HIV risk-reduction counseling. It helps clients initiate and maintain behavior change to prevent the transmission of HIV; it also addresses competing needs that may make HIV prevention a lower priority. CRCS addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS involves the coordination of intensive prevention activities and often involves close collaboration with Ryan White Comprehensive AIDS Resource Emergency Act (RWCA) case management providers. CRCS prevention activities might include conventional risk-reduction objectives such as

- decreasing the number of sex partners and needle-sharing partners
- increasing use of condoms
- adhering to medication
- taking an active role in medical care
- abstinence

- referral to needed psychological, social, and medical services affecting risk behavior (e.g., treatment for mental health and substance abuse, diagnosis and treatment of sexually transmitted diseases)

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

CRCS for Persons Living with HIV has the following 6 core elements:

- Provide CRCS as intensive, client-centered HIV risk-reduction counseling, and include conventional case management services only when the client does not have access to those services.
- Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.
- Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission.
- Recruit persons who expressed some degree of commitment to ongoing risk-reduction counseling.
- Hire case managers with the appropriate training and skills to complete the CRCS activities within their job description.
- Develop clear procedure and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

CRCS for Persons Living with HIV has the following key characteristics:

- Develop a client recruitment and engagement strategy.
- Screen and assess clients to identify those who are at highest risk and appropriate for CRCS.
- Develop a written, client-centered prevention plan.
- Provide multiple HIV risk-reduction counseling sessions.
- Actively coordinate services with follow-up. To avoid duplication of services, prevention case managers should not provide case management services to the extent that they are already provided by existing case management systems.
- Monitor and reassess clients' needs, risks, and progress.
- Discharge clients from CRCS once they attain and maintain their risk-reduction goals. Agencies should establish protocols to classify clients as "active," "inactive," or "discharged," and outline the minimum active effort required to retain clients.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for CRCS for Persons Living with HIV are as follows:

Recruitment and Engagement

Providers should ensure that clients understand the reason for a referral to CRCS, the role of the CRCS program, and the role of the CRCS provider. The CRCS counselor or other designated recruitment specialist should work with the client to obtain written, informed consent describing all relevant policies and procedures (including the confidential and voluntary nature of the service) and indicating their commitment to participate in ongoing risk-reduction counseling. Clients should be given a copy of this consent form, and the original should be maintained in the client's record. Each client should have an individual confidential record, and all records should be kept in a locked file cabinet; access should be limited to the prevention case manager and his or her immediate supervisor.

From the beginning, CRCS providers should develop a personal and working relationship with clients. This process, also known as engagement, may help clients feel comfortable discussing their behaviors. However, given the psychosocial challenges in the lives of CRCS clients, many potential clients tend to stay on the fringes of the program for some time before being ready to become fully engaged in CRCS. Agencies that provide CRCS should prepare for this by developing other engagement strategies, such as referring these clients to client support groups. In such groups, clients often develop more interest in discussing risk issues over time and, thus, their willingness to commit to CRCS increases.

Eligibility Screening and Initial Assessment

All clients must be screened for eligibility for services. Appropriate screening procedures should be developed to identify persons at highest risk for transmitting or acquiring HIV. The initial assessment should address transmission risks for HIV and other sexually transmitted diseases; substance use or abuse; and medical, psychological, and social needs. The client contacts should be conducted in a culturally appropriate manner.

Developing a Prevention Plan

After completing the initial assessment, the CRCS provider and the client should begin to develop a prevention plan and sign it. The prevention plan is a work in progress, probably will not initially define all of a client's prevention needs, and is subject to modification throughout the client's enrollment in CRCS. In fact, CRCS is most successful when the client focuses on a small number of goals at 1 time. CRCS providers should coordinate with the RWCA, Medicaid, or other case managers, whenever possible, to provide the best possible constellation of services. The initial plan should

- outline and define 1 or 2 risk-reduction behavioral goals and strategies for behavior change, including appropriate and SMART objectives. SMART stands for
    - Specific
    - Measureable
    - Achievable

    - Realistic
    - Time-phased
- include referral to medical care, if needed
- address adherence to retroviral medication, if appropriate
- include referral for evaluation and treatment of sexually transmitted diseases, tuberculosis, hepatitis, and other related health concerns
- address referral for substance abuse treatment or mental health services, if needed
- address partner counseling and referral services
- outline plans for referral follow-up

Delivering Counseling Sessions

Although some risk-reduction discussions can begin as soon as the CRCS counselor contacts a client, the CRCS counselor will intensify CRCS session when risk behaviors have been identified and appropriate risk-reduction strategies have been outlined. Counseling sessions are aimed at meeting the identified behavioral objectives. These sessions may include education, skill development, role-playing, and support. Case notes should be filed after each session with a client, indicating, at a minimum, the following:

- The goal and objective(s) addressed during the session, with specific steps agreed upon to accomplish each objective. Remember that small steps are often more realistic and, once accomplished, can lead to larger steps.
- Progress toward the goal. Remember to reward even small accomplishments.
- Barriers to behavior change and the way these are being or will be addressed
- Review of risk-reduction objectives and any needed modifications
- Referrals made and plans for follow-up
- A plan for the next session

Coordinating Services

To avoid duplication of services, CRCS providers should ensure active coordination of services with follow-up. Prevention case managers should not provide case management services to the extent that they are already provided by existing case management systems. If referrals are a part of the prevention plan, the CBO should have a standardized written referral process; a system should be in place to ensure availability and access to these referral services and to track their completion. This system might include agreements, such as memoranda of agreement with relevant service providers. Before communication between agencies begins, written informed consent for sharing client information should be obtained from the client. Medical and psychological services should be available in case of emergencies, and referral agreements for these services should be in place before initiating CRCS. Current referral and access information for all community providers should be maintained.

Following Up

Ongoing needs assessment is essential for monitoring progress toward CRCS goals and monitoring changing needs of the client. Prevention plans must be updated to reflect any change. After the client is able to maintain risk-reduction behaviors, the client and the CRCS provider should determine whether the client is ready for discharge from CRCS. Agencies implementing

CRCS must have discharge protocols in place to ensure that discharged clients are connected to needed services and resources and that they are able to return to CRCS, if needed.

RESOURCE REQUIREMENTS

People

CRCS needs staff members who are familiar and comfortable with the client base. Prevention counselors have commented that prior work experience in HIV services helped them with the delivery of CRCS. In addition to training on CRCS (e.g., training in helping clients set goals and objectives and particularly on risk-reduction counseling), CRCS staff members should have worked with or at least know how to recognize people with mental health issues (e.g., licensed counselors or other mental health providers) because CRCS clients often need mental health services. In addition, the number of staff members for CRCS depends on the number of clients that a CBO expects to serve, the needs of those clients, and what other services are offered in the area. A typical caseload will include no more than 20 clients for each full-time (or equivalent) CRCS provider.

In areas with limited referral services, CRCS providers will need to meet a wide range of client needs themselves; thus, they may need to reduce the number of clients that they can see. In areas with ample referral services, CRCS providers will be able to refer more clients and carry a higher caseload, with which they can concentrate on their clients' risk-reduction needs.

Space

CRCS needs a location that is

- easy to get to using public transportation
- private and secure, so that confidentiality can be maintained
- quiet and without interruptions (such as people entering and exiting the room or outside noise)
- close to other services that CRCS clients are accessing

Providers may need to meet clients outside of an office setting. When they do, efforts should be made to secure a location that will assure the confidentiality and safety of the client and CRCS counselor and minimize distractions and interruptions. Regardless of where actual CRCS sessions occur, the CBO implementing the intervention must ensure that all records are maintained securely in accordance with the agency's policy for protecting client confidentiality. In addition, agencies need to develop protocols to assure safety of clients and staff at all times.

RECRUITMENT

CRCS programs rely on referrals and recruitment to establish a client base. To recruit clients for CRCS, programs are often more successful at recruiting clients when they are located in an agency or community setting that offers other services (e.g., outreach, counseling and testing

services, Ryan White case management, medical care, assessment and treatment of sexually transmitted diseases, substance abuse treatment, and mental health services) for the target population. In this way, clients can be referred to CRCS from existing services. If these services are not offered on site, referral agreements from agencies providing these services should be established. Incentives (for example, bus tokens, hygiene kits, t-shirts) can be used to increase participation.

POLICIES AND STANDARDS

Before a CBO attempts to implement CRCS, the following policies and standards should be in place to protect clients, the CBO, and the prevention case manager:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, informed consent signed by the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities

around HIV-infected clients and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance with decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and health department and CBO prevention programs for persons living with HIV. All persons screened for CRCS, regardless of eligibility, should be referred to services relevant to their needs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing CRCS:

Providers

Experience and Supervision

Providers of CRCS services might find it helpful to have experience working in the fields such as mental health or substance abuse services (e.g., licensed counselors or mental health providers) and HIV prevention, although experience working with the target population is also helpful. CRCS providers should meet at least monthly with either a direct supervisor or with a peer supervisor. Supervisors, other management personnel, and those providing CRCS services directly to clients are strongly encouraged to participate in appropriate training that covers the foundations of CRCS as well as the specific CRCS approach used by the agency in which they work. Training resources can be accessed by contacting your CDC Project Officer or state health department.

Session Review

CBOs should have in place a mechanism to ensure that all sessions address the prevention plan, either by focusing on risk reduction specifically or on contextual issues that are related to risk behavior. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity.

Record Review

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all

participants and that session notes are of sufficient detail to assure that clients are participating actively.

Clients

Clients' satisfaction with the services and their comfort should be assessed periodically. Process monitoring systems should also track the number of sessions each client attends, as well as reasons for not attending.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

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